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ATTACHMENT I

INDIANA CHRONIC DISEASE MANAGEMENT PROGRAM

Based on the chronic care model, the Office of Medicaid Policy and Planning (OMPP) and the Indiana State Department of Health have developed and implemented a disease management program for the Hoosier Healthwise and *Medicaid Select* population called the Indiana Chronic Disease Management Program (ICDMP). Detailed information on ICDMP is available on the website at: www.indianacdmpprogram.com. ICDMP is a comprehensive program for managing asthma and other chronic conditions and is currently available to eligible members enrolled in the PrimeStep program via the state's ICDMP vendors. Contact information for the ICDMP program vendors is available in the procurement library.

It is OMPP's goal to make certain core elements of the asthma ICDMP available to all eligible Hoosier Healthwise members regardless of delivery system. However, OMPP appreciates the medical management experience and program creativity that a MCO can provide. To that end, OMPP is providing three options, described below, for the MCO to determine how best to develop and implement the disease management program for their Hoosier Healthwise members. These options are:

- Option 1: Purchase program (i.e., Buying the ICDMP program components directly from the State's vendors)
- Option 2: MCO-specific (i.e., Proposing an alternate version of the ICDMP)
- Option 3: Hybrid program (i.e., Proposing an alternate version for a portion of the program and buying a portion directly from the State's vendors)

The subsections below frame the core elements the asthma disease management program, list the implementation options available to the MCO, and provide a listing of the performance measures and health outcomes to which the MCO will be held.

1.0 Core Elements And Associated Requirements

There are five core elements in ICDMP that the MCO must include in its approach to disease management for asthma.

1.1 Disease Management Guidelines

OMPP, in collaboration with the Indiana State Department of Health's Indiana Joint Asthma Coalition, has developed Indiana's Consensus Clinical Guidelines for the treatment of asthma. The MCO must use Indiana's Consensus Clinical Guidelines. The MCO is welcome to supplement these materials, if approved by OMPP. The Consensus Clinical Guidelines are available on the ICDMP website.

1.2 Educational Materials for Members and Providers

OMPP, in collaboration with the Indiana State Department of Health's Indiana Joint Asthma Coalition and the Indiana University School of Medicine's Regenstrief Institute for Health Care, has developed educational materials for both members and providers. The MCO must use these educational materials. The materials are available on the ICDMP website. The MCO is welcome to supplement these materials, if approved by OMPP.

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1.3 Chronic Disease Management System (CDMS) Data Registry

The Chronic Disease Management System (CDMS) Data Registry is an electronic patient registry that tracks eligible members' encounters with the ICDMP, including phone-based intervention (call center) activity, in-person intervention activity, PMP encounters with the member. In addition, CDMS includes asthma-related fee-for-service claims otherwise unavailable to the MCO. Future functionality includes inputting MCO encounter data into CDMS.

The MCO must provide OMPP accurate and complete data from its disease management program. The MCO may enter the data into CDMS on an on-going basis or submit it directly to OMPP on a monthly basis for downloading into the CDMS database.

The State provides CDMS at no charge to the MCO and the MCO's contracted PMP offices. The MCO may provide CDMS at no charge to their contracted PMPs. The MCO must assist their contracted PMPs in installing and understanding the CDMS program. OMPP will provide a training session to the MCO on how to install and use CDMS. OMPP is willing, on a case-by-case basis, to coordinate CDMS deployment with the MCO, if the PMP utilizes CDMS for their *Medicaid Select* membership in addition to their RBMC membership. OMPP offers CDMS phone-based technical support to both the MCO and PMPs via the ICDMP Call Center Administrator. The MCO can use CDMS as an administrative tool to retrieve information. Additional information on CDMS can be found on the ICDMP website.

1.4 Phone-based Interventions

The MCO must have phone-based interventions for low severity members. OMPP has contracted with the ICDMP Call Center Administrator to make outbound educational and health assessment calls to eligible ICDMP members, to receive members' inbound calls, and to provide a link among physicians, the program and the member, when needed. The phone-based interventions have been developed by OMPP in collaboration with the Indiana University School of Medicine's Regenstrief Institute for Health Care. If selecting "Option 2" or "Option 3", the MCO can propose an alternative approach that provides an equivalent or similar level of intervention as described below:

- Provide telephonic education and care management via outbound calls. Members must be contacted at least quarterly.
- Provide a health assessment on all members regardless of severity.
- Use the scripts developed by OMPP and Indiana University School of Medicine's Regenstrief Institute for Health Care (script for the first call is available in the procurement library).
- Input all information retrieved during any encounter with a member into CDMS.
- Distribute educational materials to participating members.

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- Distribute Indiana’s Consensus Clinical Guidelines for the treatment of asthma and educational materials to all PMPs in the network.
- Receive inbound calls from members, and provide a link among physicians, the program and the member, when needed.

1.5 In-person Intervention: Qualified Healthcare Professional (QHP)

The MCO must provide in-person interventions for high severity members. OMPP has contracted with two Nurse Care Management Administrators [Indiana Minority Health Coalition (IMHC) and the Indiana Primary Health Care Association (IPHCA)] to conduct in-person intervention for high severity members using nurses. The MCO must have qualified healthcare professionals (QHPs) provide high-severity members self-management skills, provide patient education, monitor care plans that the PMP has developed, ensure medication compliance as directed by the member’s PMP and must be able to travel to provide in-person interventions in the member’s home or the PMP’s office. The Federal regulation 42 CFR 438.2 defines “health care professional”.

OMPP requires both IMHC and IPHCA to supply the high severity member with three levels of intervention, described below:

- Phase I (Initial intervention)
- Phase II (Reinforcement)
- Phase III (Transition to call center)

If selecting “Option 2” or “Option 3”, the MCO may propose an alternative approach that provides an equivalent or similar levels of intervention, as described below. However, for high severity members in the reinforcement phase, the MCO must include similar levels of intervention described below provided by a nurse care manager (NCM) or other qualified healthcare professional (QHP).

1.5.1 Phase I: Intervention

The Intervention Phase includes the following criteria:

- The QHP must contact the member via telephone to inform him/her of the disease management program and to encourage his/her participation.
- The QHP must contact the member PMP in person, if possible, or via telephone to inform him/her of the disease management program and to develop a care plan approach for the member.
- The QHP must conduct one in home health assessment with the member to perform a health visit and begin to identify the member’s self-management health care goals
- The QHP must, at a minimum, conduct one telephonic contact to provide education and training to the member and continue to develop their relationship

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- The QHP will make face-to-face visits, preferably one in the PMP office, to develop, monitor and expand the member's self-management plan, deliver health education and training. Conduct a minimum of one follow up meeting, with more as necessary, for establishing and following through on patient's goals.
- The QHP will work with the member on problem identification and problem solving interventions throughout this phase (at a minimum, telephonically) to reinforce member's self-management plan, set new goals, provide support and supplemental education, and assess the member's progress
- The QHP is required to:
 - Advise the PMP of the member's progress in attaining personal self-management goals.
 - Work with the PMP to modify the care plan approach, if necessary.
 - Notify the PMP when the member is being transitioned to the low severity group (call center intervention).

1.5.2 Phase II: Reinforcement

In the Reinforcement Phase, the disease management program includes:

- Ensuring that the QHP calls each member at least once a month to discuss the member's self-management goals, identify and address barriers and set new goals, as appropriate.
- Ensuring that the QHP, in conjunction with the member, develops a transition plan that enables the member to continue self-management plan activities.
- Conducting the reinforcement phase for at least two months.
- Informing the member's PMP of transition to the call center and providing PMP with documentation of the member's progress while in nurse care management.

1.5.3 Phase III: Transition to Call Center

During Phase III, the member will transition to the low severity category and the Call Center will provide the member with support, as detailed above in Section 1.4.

2.0 Member Selection and Implementation Options

The MCO must provide asthma disease management services to all eligible members who choose to participate in the program. The MCO must detail how it will identify and stratify members with asthma to participate in its program in either a high or low severity categories. The identification and stratification algorithm should closely reflect OMPP's method (available in the procurement library). The algorithm must be approved by OMPP prior to program operations and any changes to the algorithm must be approved by OMPP.

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OMPP has designed three options for disease management implementation described in the chart and narrative below. The chosen approach and description of the implementation plan must be approved by OMPP prior to implementation. For any option listed below, the MCO must consistently meet or exceed the outcome measures listed in Section 3.0. If MCO performance does not meet or exceed the State's established targets using Option 2 or 3, OMPP may require the MCO to purchase the State's disease management program.

| MCO Options | Core Elements | | | | |
|---|--|---|---|---|---|
| | Indiana Consensus Asthma Guidelines | Patient Education Materials | CDMS Patient Registry | Phone-Based Interventions | In-Person Intervention |
| <u>Option 1:</u> Purchase program from state's vendors | ICDMP Guidelines Required (MCO may supplement) | ICDMP Materials Required (MCO may supplement) | Required | Required via ICDMP Call Center Administrator | Required via IMHC and/or IPHCA |
| <u>Option 2:</u> MCO-specific program | ICDMP Guidelines Required (MCO may supplement) | ICDMP Materials Required (MCO may supplement) | Use CDMS or supply data to OMPP in specified format | MCO call center or OMPP-approved MCO alternate intervention | MCO QHP or OMPP-approved MCO alternate intervention |
| <u>Option 3:</u> Hybrid program | ICDMP Guidelines Required (MCO may supplement) | ICDMP Materials Required (MCO may supplement) | Use CDMS or supply data to OMPP in specified format | ICDMP Call Center Administrator or MCO call center | IMHC and/or IPHCA or MCO in-person intervention |

2.1 Option 1: Purchase Program

The MCO can purchase the State's disease management program directly from AmeriChoice (the State's vendor for ICDMP Call Center Administrator services) and the Indiana Minority Health Coalition (IMHC) and/or the Indiana Primary Health Care Association (IPHCA) (the State's vendors for the Nurse Care Management Administrator services). The MCO is free to utilize both IMHC and IPHCA or either. All three vendors have agreed to honor the price options listed below. Costs that will be honored include the following:

- In-person intervention/Nurse Care Management Administrators (IMHC/IPHCA): Nurse Care Management Administrators provide the services outlined in Section 1.5 of this Attachment and are reimbursed \$100,000 annually for each nurse. The price also includes the standard package of QHP reporting, available in procurement library, sorted by MCO. One full time equivalent (FTE) nurse care manager (NCM) per year, with a caseload of 150 members actively in intervention phase, follows members through the reinforcement phase. NCM must have a Bachelor's degree in nursing and a minimum of 1 year experience in community

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health setting or chronic disease management; or Bachelor's work equivalent of a formal nursing certificate and 3-5 years in community health setting or chronic disease management.

- Phone-based intervention/ ICDMP Call Center Administrator (AmeriChoice): AmeriChoice provides out-bound and in-bound educational calls for members, based on scripts approved by OMPP. In addition, AmeriChoice also provides CDMS user support. Per member/per month charges range from \$7.50-\$10.00, depending on the volume of members the MCO can supply to AmeriChoice:
 - 1,000 members - \$10.00 PMPM
 - 16,000 members - \$7.50 PMPM

The price also includes the standard package of call center reporting sorted by MCO. Copies of the standard package of call center reports are available in the procurement library.

2.2 Option 2: MCO-specific Program

The MCO can develop an alternative asthma disease management program modeled on the State's program. The State encourages the MCO to propose creative, innovative approaches to achieve improved health care quality, and ultimately improved quality of life, for members for any "Option 2" response. In developing its own program the MCO must:

- Design the program to meet certain requirements, listed in the chart and narrative above for Option 2. The alternative approach must provide the equivalent or similar level of intervention as noted in the narrative above.
- Detail how it will identify and stratify members with asthma eligible for the program.
- Either use CDMS to report program data or submit data to OMPP for CDMS submission.
- Specify and detail the interventions and their frequency.

2.3 Option 3: Hybrid Program

This option provides the MCO with the flexibility to develop a portion of its disease management program in-house, but contract directly with AmeriChoice for ICDMP Call Center Administrator services and/or with IMHC and/or IPHCA for Nurse Care Management Administrator services. The State encourages the MCO to propose creative, innovative approaches to achieve improved health care quality, and ultimately improved quality of life, for members for any "Option 3" response. Any portion of the program the MCO would like to develop in-house should reflect the requirements noted in the grid above and in the "Option 2" narrative.

In addition the MCO can negotiate with any of the State's ICDMP vendors for any package of service. Examples of alternative approaches include, but are not limited to:

- The MCO can negotiate with Nurse Care Management Administrators to use social workers or another QHP instead of nurses for in-person intervention.

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- The MCO can negotiate with Nurse Care Management Administrators to supply additional services for other members of the MCOs population, such as intervention for high-risk pregnancy or outreach to members who use the emergency room inappropriately.

3.0 Performance Measures and Health Outcomes

Regardless of the disease management option selected above, the MCO must collect and submit program data to OMPP for performance measures and health outcomes, as outlined in the “Core Elements” chart above, each month (except the HEDIS measure, which will be submitted on the standard submission schedule). The measures are based on the ICDMP’s charter (available in the procurement library). If the MCO selects Option 2 or Option 3 described in Section 2.0 and the MCO’s performance does not meet or exceed the State’s established targets, OMPP may require the MCO to purchase the State’s disease management program (i.e., Option 1).

At a minimum, the MCO must report on the following measures quarterly, broken out by month, and must meet the performance standards as described below:

- At least 90 percent of all MCO members with persistent asthma will have a written action plan at home and in the medical record.
- At least 70 percent of MCO members with persistent asthma will have a documented self-management goal.
- A 30 percent to 50 percent reduction from a mutually agreed upon baseline number of emergency department/urgent care visits for asthma.
- A 20 percent to 30 percent reduction from a mutually agreed upon baseline number of hospital admissions for asthma.
- Obtain at least the NCQA Medicaid median rate for the Health Plan Employer Data and Information Set (HEDIS) measure “Use of Appropriate Medications for People with Asthma.”

4.0 Breakthrough Series Collaborative

As part of the ICDMP, the Indiana State Department of Health and OMPP are providing training in the Chronic Care Model for ICDMP participating PMPs. The Chronic Care Model is a model for health system change to improve care for chronically ill patients developed by the Robert Wood Johnson Foundation’s national program Improving Chronic Illness Care. In addition, the Institute for HealthCare Improvement (IHI) developed the Breakthrough Series Collaborative to facilitate health system change. This learning method relies on the adoption of the Model for Improvement¹. The Model for Improvement is a quality improvement strategy that demonstrates the power of rapid cycle tests of small change that build towards sustainable change within an organization.

¹ Langley G., Nolan K., Nolan T., Norman C., and Provost L., *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*.

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The MCO can send a to-be-determined number of contracted PMPs and their office staff to attend the Breakthrough Series Collaborative free of charge. OMPP and the MCO will determine participation at a later date.

The training consists of, in part:

- Collaborative learning sessions for teams from participating practices. These teams include a physician, nurse and/or office manager. The Learning Sessions allow for introduction of the Model for Improvement and the Chronic Care Model.
- Coaching and tools for physician offices to implement in their practices
- Education on CDMS
- On-going support to the practices via conference calls and list serves
- Review of the Indiana Consensus Practice Guidelines for Asthma
- Promotion of self-management skills utilizing the Stanford Self-Management Model